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# Labor Relations in Ontario Hospitals: A Question of Survival

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*The authors examine the sources of the prevalent unrest among Ontario Hospital employees. As the specific causes of the present situation are outlined separately, their inter-relationships are to be borne in mind.*

Use of the term « labor relations » implies the existence of a system of co-operation which operates to the mutual benefit of management and employees in the attainment of their respective goals and the satisfaction of their perceived needs. An essential factor for the maintenance of any co-operative system is the existence of a mutually satisfactory process for the discussion of common problems and the resolution of disputes. Furthermore, both parties must desire a harmonious relationship and must make a genuine attempt to appreciate the determinants of one another's position.

If these conditions are not met, labor exists, management exists, conflict exists, but « labor relations » is an impossibility. Surveying the events of the past decade, it is questionable whether we can claim with any conviction that labor relations is a fact in Ontario hospitals.

Unionization of hospital employees initially aroused substantial public apprehension about potential work stoppages, cost increases, and

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the implications for patient welfare. The fear of organization itself has now been allayed. The new spectre appears in the question of whether hospital employees should on moral and practical grounds be granted the right to strike. If these workers are deprived of the traditional ultimate mechanism for the settlement of disputes, is there an acceptable alternative for the achievement of labor goals ?

### **Prologue : Birth and Growth of the Strike**

To gain a broad perspective of the problems confronting the Ontario hospitals, a brief overview of the Canadian historical background is warranted.

The first Canadian hospital strike occurred in Newfoundland in 1963 when non-professional employees of the Western Memorial Hospital in Corner Brook left their jobs after two years of fruitless negotiations. The union, the National Union of Public Employees (NUPE), agreed, however, that a skeleton crew should remain on the job to ensure the welfare of the patients. Although a conciliation board unanimously recommended wage improvements and union security provisions, the Hospital Board refused to accept the recommendations. Premier Smallwood terminated the strike by establishing a one man Royal Commission to study the dispute. The union co-operated by suspending the strike for six months. Subsequent legislation prohibited such strikes and created an arbitration board for the resolution of future disagreements <sup>1</sup>.

Also in 1963, a conciliation board found in favour of a wage hike for employees of the Prince Edward Island Hospital and the Charlottetown Hospital. Here even the hospital boards conceded that the wages should be upgraded. However, the Hospital Services Commission (the Provincial Government), having budgetary authority, rejected the demands. A request for a strike vote was refused on the grounds that the Labour Relations Act prohibits striking of « necessary employees » <sup>2</sup>.

The most extensive hospital strike in Canada occurred in Quebec during the summer of 1966. The strike, which originally began at 21 hospitals, soon spread to 119 Quebec institutions involving 32,500 non-professional workers. The chief issue in the strike, which lasted from July 15 to August 4, was wages although other topics came under dis-

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<sup>1</sup> « NUPE Hoists Hospital Strike », *Canadian Labour*, (May 1963), p. 24.

<sup>2</sup> « P.E.I. Hospital Workers Take Wage Plea to Public », *Financial Post*, (July 20, 1963), p. 5.

cussion and were included in the eventual agreement. In dealing with the walk-off Premier Johnson ousted hospital negotiators from the bargaining table, replacing them with a single administrator supported by the Government and representing all the hospitals concerned. Settlement was reached two days later <sup>3</sup>.

Turning to the Ontario scene, the incident which precipitated an investigation by the Ontario Government was a threatened strike of the Toronto General Hospital (TGH) by the Building Services Employees' International Union (BSEIU) <sup>4</sup>. While the union and the TGH were separated on wages, a more serious issue was union security. The union had taken a strike vote and was in a position to strike, but the hospital's capitulation prevented a walk out. This was definitely an immediate victory for the union but even more important, the action resulted in substantial government interest. There was considerable question as to whether the hospital could have operated without the services of the almost 1,000 workers involved <sup>5</sup>.

The BSEIU was simultaneously involved in disputes with two other hospitals : Plummer Memorial in Sault Ste. Marie and the Sydenham General in Wallaceburg, the latter being a dispute which went back three years and was becoming more and more threatening.

The results of this pressure was the establishment, in 1963, of a three man Royal Commission, headed by Judge C.E. Bennett with a management representative, R.V. Hicks, and a labour representative, H. Simon, Ontario director for the Canadian Labour Congress. The Bennett Commission was charged to report on the feasibility of compulsory arbitration as a mechanism for the settlement of disputes arising in the negotiation of collective agreements between hospitals and their employees. Although the Bennett Commission recommended that compulsory arbitration be applied only when patient care is adversely affected or seriously threatened, the Ontario Legislature with the passage of the Hospital Labor Disputes Arbitration Act in 1965, not only imposed compulsory arbitration, but also prohibited strikes and lock-outs in hospitals. This provision becomes effective if conciliation is unsuccessful and if a further seven days of direct

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<sup>3</sup> « Quebec Hospital Strike Ended by Government », *Labour Gazette*, (October 1966), p. 560.

<sup>4</sup> Later to become known as the Services Employees' International Union (SEIU).

<sup>5</sup> « Hospital Staff Arbitration : Beginning New Labour Trend ? » *Financial Post*, (May 18, 1963), p. 34.

negotiations between the hospital and employees does not produce agreement.

The decision of the provincial government to initiate legislation to prohibit hospital strikes was strengthened by another incident; a three month strike at the Trenton Memorial Hospital by the BSEIU. The hospital operated with strike breakers but enough friction resulted to warrant a provincial inquiry. Eventually, the strike was settled by the Royal Commission itself, acting as a committee of inquiry.

By this time hospital unions had emerged from their obscure position in Canadian society. More than 30,000 non-professional employees of hospitals had been organized. Of these, approximately one third belonged to the BSEIU and the other two thirds to two unions that merged into the Canadian Union of Public Employees (CUPE).

Criticisms of the implementation of the Hospital Arbitration Act have been expressed by the professional, semi-professional, and non-professional sectors of hospital staffs. Other common difficulties in negotiations have also been encountered, although the particular status and role of each group has brought differing responses and methods of registering dissatisfaction.

The causal factors of the unions' nascent struggle remain as the sources of the prevalent unrest among hospital employees. Each problem, while significant in itself, cannot be considered in isolation if the magnitude of the difficulty is to be appreciated and solutions found before a labor-management-government impasse is reached. As the specific causes of the present situation are outlined, the inter-relationships among wage levels, governmental wage control, compulsory arbitration, and the prohibition of the right to strike must be borne in mind.

### **Crippling Effects on Unions**

#### **WAGES AND WAGE CONTROL**

Hospital employees have traditionally occupied a low place on the wage scale in both the United States and Canada. From 1966-68, there were 57 work stoppages among hospital employees in the United States. During 1966-67, strike participation was found primarily in the nursing and other professional groups. However, in 1968 strike concentration

shifted to the semi-professional and non-professional health care employees<sup>6</sup>.

This growing emphasis on removal of the wage disparity between hospital workers and other sectors of the labor force is also evident in most Canadian provinces where the recent union demands have stressed the fact that hospital employees through low wages are being required to subsidize the public. To compensate for the years of depressed levels of remuneration, the unions are demanding large wage increases to place hospital workers on an economic par with similar workers in private enterprises.

Proceeding towards this goal, the Canadian Union of Public Employees (CUPE) obtained in 1967 wage increases between 17% and 30% for hospital employees in British Columbia. Also in 1967 it was regarded as a breakthrough when the minimum wage level for male hospital workers in Toronto and Hamilton rose above \$2 per hour<sup>7</sup>. An indication that further steps towards equity may be anticipated occurred in 1969 when the Service Employees' International Union (SEIU) gained a 25% increase over two years for employees in six Ontario hospitals in Brantford, St. Catherines, Niagara Falls, Welland and Toronto<sup>8</sup>.

Recent awards in Ontario have often been in contravention of the wage increase guidelines established by the Ontario Hospital Services Commission (OHSC). The economic influence of this non-participating third party to the collective bargaining process is a major source of dissatisfaction for employees, management and arbitration boards. Variations of the wage ceiling situation are present across Canada. Dealing first with the Ontario experience, the OHSC supplies capital and operating funds to the province's hospitals and holds budgetary authority. Under this system, the OHSC establishes the total allowable increase in each hospital's budget and recommends a wage ceiling. In 1969, the increase was initially established at 6.5% and later revised to 8.5%<sup>9</sup>. Although hospitals are informed that they may exceed this amount, they are also advised that any additional increases will have to be offset by economies in other areas of their budgets. This requirement naturally places hospital administrators in an untenable position during collective bargaining.

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<sup>6</sup> *Monthly Labor Review* (December 1969), p. 32.

<sup>7</sup> « Big Pay Demands Stoke Fires », *Financial Post*, (October 7, 1967), p. 3.

<sup>8</sup> « Toronto Plumbers Labor's Bellwether », *Financial Post*, (July 5, 1969), p. 10.

<sup>9</sup> *Ibid.*

In 1969 arbitration boards established to settle disputes in Windsor and Brampton ignored the OHSC guidelines in making wage increase awards.<sup>10</sup> The arbitration board report of July, 1969 for assessment of the disagreement between the Hamilton Civic Hospitals and the Canadian Union of Public Employees recommended a 20% wage increase<sup>11</sup>.

Similar situations have been encountered in other provinces. For example, in 1967, after conciliation the Central Newfoundland Hospital Corporation and CUPE reached agreement on wage increases for nursing assistants, orderlies, maids, kitchen and laundry workers. However, the increase was denied by the provincial Department of Health which controls the Corporation's budget. The Saskatchewan Government in 1969 established a wage increase ceiling of 6% for hospital workers.

The lack of freedom in collective bargaining is also encountered in Quebec where the hospitals are legally able to conclude an agreement with employees but the government reserves the right to impose a settlement. Being forced to operate within the confines of wage ceilings established by legislative bodies which do not take part in the bargaining process, Canadian unions and hospital employees are unable to undertake true negotiations. The arbitration board report for the settlement between CUPE and the Hamilton Civic Hospitals emphasized that the OHSC, if it continues to retain the ultimate decision-making power in wage matters, must play a direct and active role in the bargaining process. In June 1969, the SEIU in a protest to the Ontario Minister of Health stated that either the OHSC must, by withdrawing its power to set wage guidelines, allow unions to bargain freely with hospitals, or the OHSC must assume sole responsibility for bargaining with the unions.

## RIGHT TO STRIKE

Compounding the problem in several provinces is the creation of legislation which prohibits hospital workers from utilizing the strike as a mechanism for gaining improved wage settlements. In Saskatchewan, while workers may strike, the government has the right to enforce legislation to end the strike and submit the dispute to compulsory arbitration. If a strike continues more than 10 days beyond the application of this legislation, the government may dissolve the union. In spite of this threat,

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<sup>10</sup> *Canadian Labor*, (May 1969), p. 12.

<sup>11</sup> Canadian Union of Public Employees (local 794) and Board of Governors of Hamilton Civic Hospitals, *Report of the Arbitration Board*, July 25, 1969.

Saskatchewan hospitals in 1969 experienced a 50% increase in the number of strikes with recent walk-outs occurring at Prince Albert and Estevan <sup>12</sup>.

Newfoundland's Grand Falls Hospital dispute resulted in a strike which prompted the province to invoke the Labor Relations Act and declare a state of emergency in the hospitals. This legislation forced the hospital workers to return to work under threat of heavy fines and decertification of the union.

Although hospital workers in Quebec may strike, the possibility of government counter legislation is effective in instilling unions with caution in the use of the strike.

In Ontario, dissatisfaction with the bargaining environment and the economic situation has become severe enough for CUPE to state that illegal strikes may be required for removal of the injustice apparent in the hospital wage structure <sup>13</sup>. The White Paper submitted by the Canadian Union of Public Employees to the Ontario Legislature in June 1969 maintains that while the ability to initiate strike action is essential for successful negotiations, the existence of the right does not imply that it will be implemented irresponsibly. If used with discretion, the Union points out, strikes in hospitals would not be detrimental to patient care or damaging to the public interest. A strike, therefore, is not necessarily a negative or destructive mechanism used for satisfying demands at the public expense.

#### COMPULSORY ARBITRATION

A further hinderance to the development of maturity in the bargaining process is the presence of compulsory arbitration. This requirement, when considered in relation to governmental influence, leads both management and labor to rely upon the ultimate intervention of a third party to achieve reconciliation of differences. CUPE has expressed its preference for a system which would allow the parties to accept responsibility for direct negotiations without compulsory referral to a third party, whether mediator, conciliator or arbitrator. With a minimum of restrictive legislation and with the possibility of voluntary arbitration, it is contended that mutually satisfactory settlements can be obtained and that management-labor interaction may be improved.

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<sup>12</sup> « Hospital Standoff on the Prairies », *Financial Post*, (December 6, 1969), p. 22.

<sup>13</sup> *Canadian Labor*, (May 1969), p. 12.



Among the difficulties presently encountered by hospital unions are : (1) regional wage disparities ; (2) lack of experience in bargaining ; and (3) the fact that the public hospital system creates, in effect, an employer monopoly on a provincial basis. Efforts are being made to establish province-wide bargaining, with allowances for regional requirements, for hospital employees. This position is supported by CUPE and was also suggested in 1969 by an Ontario arbitration board<sup>14</sup>. However, more economic research will be required before regional or provincial bargaining can be implemented. The monopoly situation is somewhat ameliorated by competition among the provinces for hospital workers and by the ability of employees to move to other fields of employment. For instance, in Ontario last year, 50% of the hospital orderlies and 33% of the nurses left the hospitals (most, one assumes), to take up more lucrative employment<sup>15</sup>.

### The Condition of Professional Groups

Thus far, the discussion has centred on the non-professional components of hospital staffs. However, there is organizational and bargaining activity also emerging within the professional hospital employee groups. As the entrepreneurial aspects of professionalism recede and as professionals become salaried employees, the need for collective action becomes evident. The development of unionization among professionals is a slow process due to a variety of factors among which are the traditional preference of professionals to make individual decisions ; the professional mistrust of the quality of union leadership ; the question of whether unionization is consistent with professional status ; and the influence of collective action on professional ethics.

As E.M. Kassalow has noted, the increase of social security measures in the field of health care has brought a consolidation of « health consumers ». The accompanying decline in the personal relationship between professional and patient is resulting in a parallel grouping of « health producers » to establish through negotiation appropriate fee structures<sup>16</sup>. In Quebec, since 1960 the union membership of salaried hospital employees has been increasing rapidly, including in addition to nurses, para-medical staff such as psychologists and social workers.

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<sup>14</sup> CUPE (local 794) and Hamilton Civic Hospitals *op. cit.*

<sup>15</sup> *Canadian Labour*, (May 1969), p. 12.

<sup>16</sup> « Emerging Sectors of Collective Bargaining », *Labor Gazette*, (June 1968), p. 320.

Among nurses, initial attempts to influence the terms and conditions of employment involved the issuance by the Canadian Nurses' Association of recommended personnel policies with the hope that individual nurses would adhere to these principles in their own negotiations. This measure had little effect with the result that nurses' salaries were frequently lower than those of organized X-ray and laboratory technicians<sup>17</sup>. Discontent with heavy work-loads, poor working conditions, and salaries which are inequitable has led nursing associations in all ten provinces to undertake collective bargaining and to establish programmes to familiarize nurses with negotiation principles and procedures.

The bargaining situation varies from province to province. In some areas, nurses may bargain under general provincial labor legislation ; in others the provincial nurses' association, which is also the licensing body, is specifically designated as the bargaining agent ; and in other provinces, bargaining is undertaken through joint agreements with employers, although provincial legislation excludes nurses from bargaining under the labor act.

In British Columbia, province-wide agreements are negotiated between the Registered Nurses Association and the British Columbia Hospital Association. These groups may then submit a joint representation to the government, which is the budgetary authority, for increases in hospital income and salaries. Nurses in British Columbia retain the right to strike. Province-wide bargaining also occurs in Saskatchewan, although compulsory arbitration is required for dispute settlement. Quebec nurses did not exercise their bargaining rights until 1966 when the local association, the United Nurses of Montreal, was organized. This association engaged in a very successful strike in July of 1966.

In Ontario, 1200 nurses have organized under the Labor Relations Act in 30 collective bargaining associations, which negotiate with hospital boards at the city county levels. The problem of co-ordinating the action of Ontario nurses is aggravated by the fact that, unlike other provinces, registered nurses are not required to be members of the Registered Nurses Association of Ontario. Therefore, the Association in making representations to the provincial government is unable to claim to speak for all nurses with in the province.

During disagreements, nurses in Ontario have avoided the requirement for compulsory arbitration through the use of a procedure known

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<sup>17</sup> CORMICK, G.W., «The Collective Bargaining Experience of Canadian Registered Nurses », *Labor Law Journal*, (October 1969), p. 669.

as 'grey-listing'. Under this system, all nurses are requested to refuse to accept employment with a hospital or county health board which does not reach agreement with a local bargaining unit. This mechanism has proved successful in negotiations with Peel County in 1966 and with the joint Stormount, Dundas, and Glengarry board in 1967. In 1969, following the breakdown of negotiations between the Association and the Hamilton School of Nursing, a six week strike of all professional nursing staff ensued resulting in a settlement favourable to the nurses.

With the exclusion of supervisory personnel from the bargaining unit, local nurses' associations have been afflicted by a lack of leadership. To rectify this difficulty, the Canadian Nurses Association has established a Social and Economic Welfare Commission which provides research and advisory services for provincial groups. Provincial associations have recently been hiring personnel who are skilled in negotiation procedures.

In Ontario, nurses' groups may gain bargaining strength as a result of the approval by the Ontario Hospital Association (OHA) of joint bargaining rights on a regional basis for nurses and other paramedical personnel<sup>18</sup>. Subsequent to consultations with hospitals having nurses' associations, a working committee of the OHA prepared a proposal outlining procedures for the institution of joint bargaining for nurses. By June, 1970, seventeen hospitals had given approval in principle to a system of negotiations which would provide a master agreement to govern relationships between the participating hospitals and nurses' associations<sup>19</sup>. Supplementing the regional master agreement would be individual contracts between each hospital and the appropriate association. Although the time required for preparation precludes the introduction of group bargaining during the 1970 negotiations, representatives of the R.N.A.O. have agreed to the principle.

A national view illustrates that provinces with strong collective bargaining units have obtained the greatest wage increases. These provinces are British Columbia, Ontario, Quebec, and Prince Edward Island, which have been between 1967 and 1969 gained increases ranging from 17.5% to 30.3%<sup>20</sup>.

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<sup>18</sup> « Give Go-ahead to Joint Bargaining with Nursing and Other Personnel », *Hospital Administration in Canada*, (December 1969), p. 19.

<sup>19</sup> WILSON, J.C., « Group Bargaining : A Progress Report » paper delivered at the General Session of the O.H.A., October 28, 1970.

<sup>20</sup> CORNICK, G.W., « The Collective Bargaining Experience of Canadian Registered Nurses », *Labor Law Journal*, (October 1969), p. 682.

## Management : A Potential Therapeutic Force ?

### ROLE OF THE ADMINISTRATION

With the strengthening of employee organizations and the acceptance of collective bargaining as a standard procedure for establishing the terms and conditions of employment in hospitals, new emphasis is being placed on defining the appropriate role of the hospital administrator in employee relations. Hospital administrators in past years have been drawn from two major sources : individuals who possess a background in accounting or general business management ; and doctors who have transferred from medical practice to administration. Both groups lack the breadth of experience and knowledge required to function effectively in the complex task of managing a health care facility. In a new era, the trend to train and appoint professional hospital administrators indicates that an improvement in the organizational functioning of hospitals may be anticipated. Currently, in Canada, there are approximately 1,000 graduates of the Hospital Organization and Management programme <sup>21</sup>.

In a brief overview of the problems of hospital management, the observer is struck by the ambiguity of the administrator's position. He is usually an individual who is assigned heavy responsibility but little authority. He is directly responsible to the institution's board of trustees, but must be responsible to the demands of the medical staff and to the directives of the provincial government. Although his prime functions should be to plan for the maintenance and development of the hospital and to implement policies and measures approved by the board of trustees, a large proportion of his time is devoted to the reconciliation of conflicting interests to achieve established goals. Of the 1,200 public and federal hospitals in Canada, 85% are in the small or medium size categories <sup>22</sup>. These institutions, being financially unable to support a large administrative staff, rely on the manager or director to supervise daily operations, thus affording him little time to spend on the important areas of planning, cost control, operational efficiency, and personnel development.

### INCOME/EXPENSE CONFLICT

Aggravating the problem is the fact that in recent years, the Canadian Government and public have placed increased pressure upon hospital

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<sup>21</sup> « Provincial Groups Best for Administrators », *Hospital Administration in Canada* (September 1969), p. 5.

<sup>22</sup> WEIR, D.L., « Provincial Groups Best for Administrators », *Hospital Administration in Canada*, (September 1969), pp. 4-8.

management simultaneously to provide more extensive, higher quality health care services and to effect stabilization or reduction in the expenditure of public funds. Although consumer demand may increase and expenses may increase, the hospital, being subject to the OHSC price ceilings, cannot respond with an increase in rates. The concern for the financial aspects of health care has been stressed by the creation in 1969 of a Federal-Provincial committee to study the escalating costs of hospital and public health services in Canada, and to examine the wage structures and operational efficiency in these areas<sup>23</sup>. Governmental scrutiny is also emanating from the Ontario Council of Health, a body established in 1967 as a senior advisory group to the Ontario Minister of Health. The Council's report, which is expected in the near future, will include recommendations on such aspects of health as manpower, education, research, and the cost effectiveness of alternative deployment of physical and financial resources<sup>24</sup>.

In the midst of these forces to promote operating efficiency, administrators are confronted with a counter influence which will act to increase operating expenses. One of the major effects of the advent of unionization of hospital employees will be an increase in the absolute and perhaps proportionate amount of the budget allocated to wages. Since the hospital administrator has minimal control over the funds provided by the government or over the cost of labor and technology, and has no influence on the public demand for accessible, high quality services and the concomitant demand for manpower, he must direct his attention to an internal assessment of structure, operations, resources, and needs. One means of increasing the efficiency of resource utilization lies in the close analysis of the flow and assignment of work. Through restructuring the organization and combining eliminating and simplifying tasks, the administrators are providing a foundation for increased employee productivity so as to achieve a reduction in staff. To meet the problems of increasing costs, attention has been given to the possibility of several health units undertaking joint operation of common non-medical functions. If co-ordination difficulties can be overcome, substantial savings will be effected in such areas as accounting, data processing and laundry services.

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<sup>23</sup> « Secretariat Formed for Health Costs Study », *Hospital Administration in Canada*, (March 1969), p. 17.

<sup>24</sup> « Give Go-ahead to Joint Bargaining with Nurses and Other Personnel », *Hospital Administration in Canada*, (December 1969), p. 19.

Another means of controlling costs is the current emphasis on home care and out-patient clinics. While these measures may relieve the pressure on plant resources, the administrator must ensure that a decline in the quality of patient care is not an unintended consequence. However, before service innovations are implemented, comprehensive analysis of the total hospital structure is essential to diagnose and remedy possible functional disorders.

#### PERSONNEL RESTORATION

Budget control and other financial management techniques cannot, and should not, be applied in isolation from consideration of the human factor. In recognition of the fact that collective action arose among hospital employees in response to low salaries, absence of adequate personnel programmes, lack of job security and opportunity for advancement, and general dissatisfaction with the work environment, the American Hospital Association in 1956 adopted a Basic Personnel Policy which states, in part :

« Modern hospital management is striving to provide for all hospital employees, compensation, working conditions, and other personnel practices at least at levels prevailing for equivalent work in the community. No other principle is both fair to the community which supports the hospital and to the employees whose work makes the hospital effective »<sup>25</sup>.

The growth of unions has accentuated the need within hospitals for the development of programmes which will implement the principles implicit in this statement.

Training programmes to date have been primarily directed to new entrants to the field of hospital work. Future efforts for the achievement of reductions in costs and employee turnover must place equal emphasis on up-grading the skills of present employees. Hospitals, faced with problems similar to those experienced by private enterprise, must develop co-ordinated, extensive training programmes based on a thorough analysis of the community's potential requirements, the institution's long-range objectives, present and future needs, and present and future resources.

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<sup>25</sup> American Hospital Association, *Hospitals and Employee Groups*, Personnel Series, No. 2, (Chicago).

Among the measures suggested to eliminate inefficiencies and promote the effective utilization of hospital manpower are :

- a) recognition that stress on technical proficiency to the exclusion of concern for individual job satisfaction can only have deleterious effects ;
- b) the creation within the hospital environment of a climate which recognizes individual achievement and stimulates potential ;
- c) the introduction of financial incentives to increase productivity ;
- d) competitive compensation and benefit plans to reduce turnover and facilitate recruitment ;
- e) the application of training techniques to provide opportunities for advancement to positions of greater responsibility ;
- f) the development of new flexible training systems to meet particular needs of health workers <sup>26, 27</sup>.

Since the financial and managerial investment required for a comprehensive, productive training programme have proved prohibitive for many hospitals, there have been several centralized training programmes established in the United States to service groups of hospitals.

In Ontario hospitals, the study of manpower utilization and development has been neglected. Administrators now face the challenge of devising and implementing new methods to increase employee productivity, satisfaction and commitment.

Specifically in the area of collective bargaining, assistance is available for Ontario hospital administrators. In 1968, the Hospital Personnel Relations Bureau was established under a 1966 provincial charter, to (i) represent member hospitals in negotiation, arbitration and maintenance of collective agreements and (ii) promote interest in and study of employer-employee relations <sup>28</sup>. This voluntary group, with 83 member hospitals, has also created a Personnel Relations Committee in co-operation with the OHA and the Hospital Council of Metropolitan Toronto to develop wage guidelines in non-union areas and to undertake research on hospital job classifications.

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<sup>26</sup> U.S. Department of Health, Education and Welfare, *Report of the Secretary's Advisory Committee on Hospital Effectiveness*, 1968.

<sup>27</sup> BENNETT, A.C., « Are Our Manpower Problems Completely Insoluble ? », *Hospital Topics*, (September 1968), pp. 26-28.

<sup>28</sup> ROBINSON, E.C., « Personnel Relations Bureau is Winning Wider Acceptance », *Hospital Administration in Canada*, (January 1970), p. 35.

Although total acceptance of the Bureau's assistance has been precluded by the fear among hospitals of the loss of autonomy, a gradual movement to province-wide collective bargaining is evinced in the joint development by the OHA and the Bureau of plans for the implementation of regional bargaining. Initial efforts in this area will concentrate on contractual relations with nurses' associations. In the fall of 1970, representatives of the Personnel Relations Bureau also undertook exploratory discussions to assess the position of laboratory technologists, x-ray technicians, and physiotherapists to group bargaining. The fact that regional bargaining has successfully been undertaken by three Guelph hospitals verifies the contention that if hospitals are willing to overcome their suspicion and replace internal competition with co-operation, a co-ordinated approach to negotiations can be developed. Progression to a provincial system of bargaining for all public health care institutions, with allowance for contract variations to reflect the situations of particular types of units and geographic areas, will be to the advantage of both unions and hospitals in their relationships with each other and, more importantly, in their dealings with the government. In the creation of a cohesive structure, Ontario can benefit from examination of the provincial bargaining experience of British Columbia, Saskatchewan, and Quebec and the implementation plans of New Brunswick. However, Ontario administrators must eradicate inter-hospital hostility before unity can be achieved in the labor situation.

The onus for developing and applying the therapy which is essential for improvement of hospital performance clearly rests with each manager.

### **Pre-Conditions for Survival**

It is evident that labor relations in the mature sense does not exist in Ontario for professional or non-professional groups. Nor will it exist until the major parties involved are prepared and are permitted to bargain without externally imposed restraints.

If the present bargaining environment is maintained, the implications of wage ceilings, compulsory arbitration, and prohibition of strike action may be expected to result in a large number of illegal strikes, one-day work stoppages, rotating strikes, and slow-downs designed to inconvenience hospital management, while maintaining essential patient care facilities. The effect on organizational efficiency is obvious. However, it is to be hoped that the provincial government will heed the increasing pressure to implement measures which will allow a greater degree of freedom in the bargaining process.



Fact-finding boards have often been suggested as a substitute for compulsory arbitration. Such boards, after thorough investigation of a dispute, may formulate recommendations which will influence settlement through re-direction of public opinion or through pressure on either party. The mere threat of public exposure of certain financial facts may be a sufficient incentive to management and labor to reach settlement. As D.H. Wollet has stated, « If fact-finding is to serve as an adequate substitute for the strike, it must be sufficiently unattractive that employers and employees will usually find it preferable to make their own agreements<sup>29</sup>. In the hospital context, revelation of the provincial financial situation could consolidate the position of unions and management in opposition to the provincial budgetary authority.

Although fact-finding may perhaps be a useful mechanism in the avoidance of strike action, it is similar to compulsory arbitration in that it precludes the development of responsible, mature interaction between labor and management.

If labor relations are to survive in hospitals, the following conditions must be met :

1. Collective bargaining should take place on a provincial level between an association of hospital administrators and associations of union representatives for professional and non-professional employees. The provincial government may act in the capacity of consultant during these negotiations, but must not hold decision-making power.
2. Pre-bargaining provincial study groups, composed of equal numbers of management and employee representatives might be useful to delineate areas of potential conflict, and to create an atmosphere of co-operation.
3. The power of the Ontario Hospital Services Commission to establish wage ceilings must be removed.
4. The right to strike must be granted to hospital employees subject to a union guarantee that services essential to patient welfare will be maintained during any stoppage.
5. Hospital administrators in recognition of the role of human resources as a major input in the achievement of institutional

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<sup>29</sup> McKELVEY, J.T., « Fact Finding in Public Employment Disputes : Promise or Illustration », *Industrial and Labor Relations Review*, (July 1969), p. 541.

goals, must increase their sensitivity to employee demands and must acquire knowledge of the negotiation process.

6. Opportunities for up-grading of obsolescent managers and for training of professional administrators are required. Managers must start managing instead of merely administering
7. Attempts must be made by unions and hospitals to familiarize employees with the elements of collective bargaining and with the basic economic principles which apply to the field of public health care.

These recommendations could have the dual effect of improving the collective bargaining environment in the hospitals and the efficiency of hospital operations.

## **MEILLEURES RELATIONS DU TRAVAIL DANS LES HÔPITAUX ONTARIENS : CONDITION DE SURVIE ?**

Le terme « relations du travail » implique l'existence d'un mécanisme qui, d'une part permet le fonctionnement harmonieux de l'ensemble, c'est-à-dire à la satisfaction mutuelle des parties, et d'autre part fournit une base, voire la solution pour la résolution d'éventuels conflits. Bonne volonté et esprit de coopération sont nécessaires au développement d'une telle entente.

Si l'on considère les événements survenus ces dix dernières années, on peut douter de l'existence de réelles relations du travail dans les hôpitaux d'Ontario.

Accorder le droit de grève aux employés des hôpitaux c'est laisser la porte ouverte à de possibles exagérations et tout ce que cela comporte. D'un autre côté il est difficile de refuser aux employés une arme qui leur est nécessaire, à moins qu'il n'existe une solution de rechange. Y en a-t-il une ? C'est le but de cette étude de le démontrer.

À cause de sa signification particulière, elle est à la fois force et faiblesse pour les deux parties, la grève dans les hôpitaux est l'objet de l'attention du gouvernement. En Ontario cela résulta dans le « Hospital Labour Disputes Arbitration Act » (1965) qui impose aux parties l'arbitrage obligatoire et interdit grèves et lock-out, après un délai qui doit être mis à profit pour essayer de trouver une solution.

Cette interférence du gouvernement a un certain nombre de conséquences défavorables aux syndicats.

### **LE CONTRÔLE DES SALAIRES**

Les syndicats cherchent à obtenir la parité des salaires avec les autres secteurs de l'économie. Il arrive souvent que le résultat des efforts dans ce domaine des administrateurs et des syndicats soient réduits à néant par l'intervention d'organis-

mes, tel l'Ontario Hospital Services Commission (O.H.S.C.), qui dans les faits contrôlent la hausse des salaires. Le fait que l'O.H.S.C. ait, parmi d'autres, ce pouvoir, est la source de déception et est une restriction à la liberté de négociation. Les syndicats voudraient voir l'O.H.S.C. soit ne pas intervenir du tout, soit être le seul interlocuteur face aux syndicats.

#### LE DROIT DE GRÈVE

Dans plusieurs Provinces la législation en vigueur restreint les employés de recourir à la grève pour parvenir à leurs fins. En Ontario les syndicats énoncent l'éventuelle possibilité d'une grève illégale et revendiquent le plein droit de grève, soulignant le fait que l'existence d'un tel droit n'est pas synonyme de mauvaise utilisation.

#### L'ARBITRAGE OBLIGATOIRE

Du fait de son existence, employés comme directions ont tendance à se reposer sur lui plutôt que de chercher eux-mêmes une solution. Le recours à un arbitrage volontaire devrait rétablir une situation normale où la négociation est effective entre les deux parties.

#### LES PROBLÈMES DES DIRECTIONS

Manque de préparation pour la tâche à accomplir, trop de responsabilités et pas les pouvoirs nécessaires, caractérisent le groupe des Administrateurs d'hôpitaux. De plus le manque de personnel dans de nombreux hôpitaux, les restreint à la gestion quotidienne de l'établissement. Les ressources financières des hôpitaux ne s'accroissent pas aussi vite que les coûts. Sous la pression de syndicats les salaires ont une part croissante du budget. Puisque les administrateurs n'ont pas le pouvoir de contrôler les ressources et les coûts, la seule façon de garder un budget équilibré est de faire des économies d'échelles, en regroupant les services administratifs, soit des économies de productivité. Cela suppose l'existence de programmes de recyclage et de formation pour les employés. C'est encore un domaine négligé en Ontario. Il existe, dans cette Province, un « Bureau du personnel hospitalier » qui pourrait être utile ici. La condition à cette aide, cependant, est l'application uniforme des mesures à toute la Province, et beaucoup d'hôpitaux ne veulent pas sacrifier une partie de leur autonomie.

Pour la survie effective des relations du travail dans les hôpitaux ontariens, un certain nombre de conditions doivent être remplies. Ce qui n'est pas le cas à l'heure actuelle.

- 1) Les négociations collectives doivent se faire à l'échelon provincial. Le gouvernement étant un consultant.
- 2) Des comités paritaires doivent, avant l'ouverture des négociations, déterminer quelles questions seront à traiter.
- 3) Le droit de grève (conditionnel, dans l'intérêt des malades) doit demeurer entier. Le contrôle des hausses de salaire doit disparaître.
- 4) Un effort doit être fait du côté de la direction pour améliorer la qualité des administrateurs, dans leur travail comme dans leurs rapports avec les employés.
- 5) L'éducation des employés en matières syndicales, particulièrement le mécanisme et l'économie des négociations collectives, est à faire.